MINISTRY OF HEALTH

Evaluation Report:

Provincial Quarterly Review Meetings

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ACRONYMS

Acronym	Description
AP	Action Point
ART	Antiretroviral Therapy
CBD	Community-based Distributor
CCS	Clinical Care Specialist
CHV	Community Health Volunteer
CHW	Community Health Worker
CT	Counselling and Testing
DIM	District Integrated Meeting
DMO	District Medical Office(r)
EPI	Expanded Programme on Immunisations
GRZ	Government of the Republic of Zambia
HMIS	Health Management Information System
KII	Key Informant Interview
MCDMCH	Ministry of Community Development Mother and Child Health
MOH	Ministry of Health
PA	Performance Assessment
PIM	Provincial Integrated Meeting
PMO	Provincial Medical Office(r)
PMTCT	Prevention of Mother to Child Transmission *of HIV*
QI	Quality Improvement
QPR	Quarterly Performance Review
QTR	Quarter
TB	Tuberculosis
TBA	Traditional Birth Attendant
TI	Training Institution
TR	Trip and Event Report
TSS	Technical Support Supervision
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organisation
ZISSP	Zambia Integrated Systems Strengthening Programme

EXECUTIVE SUMMARY

From 2011 to 2012, the Zambia Integrated Systems Strengthening Programme (ZISSP), with funding from the United States Agency for International Development, supported provinces in reviewing performance through holding quarterly review meetings. A quarterly review meeting "is a mechanism through which the provincial health office assembles representatives from levels 2 and 3 hospitals, district health offices and training institutions, every quarter." ZISSP commissioned this study to assess the processes, outputs and outcomes of the quarterly performance review meetings held in the provinces and to make recommendations to improve the process as necessary. Methods of data collection included: a review of reports from previous quarterly performance review meetings, structured interviews with key informants, and self-administered questionnaires targeting all core staff members who were involved in organising the meetings or participated in one of them from the district, hospital, training institution and the province.

Findings included the following points: Adequate time was given to prepare for the meetings, and standard presentation templates were circulated to institutions to assist them in preparing their presentations. The agenda for the meetings were prepared by the provincial office, but not commonly made available to districts and institutions before the meeting. Respondents strongly agreed that a format to guide institutional presentations existed, with a standard set of indicators in each reporting category, and that they had generally adhered to the specifications of these templates. However, when templates from different provinces were compared, it was noted that differences existed in some programme areas. Key informants indicated that summarising key decisions and actions points from the meeting received enough attention, although conducting an evaluation or agreeing on agenda items for the next meeting were not done commonly done. Respondents felt that key decisions and action points were usually well-documented and understood by participants, but felt that the meeting reports were not circulated on time for institutions to discuss. Respondents strongly felt these meetings should continue because that is the only forum in which health program performance indicators were shared, including experiences, challenges and lessons learnt. However, informants felt that these meetings could be made more effective if action points were followed up and monitored.

Recommendations

- It is important that the timetable is discussed in detail before the meeting and reviewed at the start of the meeting so that timeslots are not overrun by presenters.
- There is a need to standardize the presentations outline and develop thresholds and targets for all the indicators against which progress should be assessed during the meetings.
- The provincial office should work closely with districts, hospitals and training institutions in the preparation and implementation of meetings so that their role is beyond being mere participation.
- The Provincial Medical Office should always prepare a brief that addresses all common issues that may arise from the presentations which may require feedback from the province.
- A national framework for holding meetings should be developed, focusing on standardisation with flexibility to allow for local level inclusions of individual peculiarities.

- The province should provide flexible set of dates during the year around which institutions should plan for quarterly review meetings–currently these meetings are ad hoc.
- There is a need to consider changing the presentation format from plenary throughout, to a mixture of plenary and peer reviews.
- After peer reviews, presentations should be done by thematic area to avoid monotony arising from institutions circling through similar contents.
- A standard meeting evaluation format should be developed which all provinces should be expected to complete for future improvements to the meetings.
- To improve on documentation, the note-taking template and report outline should be produced by MOH for all the provinces to use.
- To improve on follow up, the meeting approach should be restructured with emphasis on action points.

1 INTRODUCTION

1.1 Background

Since the Alma Ata Declaration[1] of 1978 on Public Health, countries all over the world, especially the developing ones, have been devising and revising national health strategies to ensure that health of their peoples is elevated beyond just the absence of disease or infirmity; close the gaps in access to health for all; increase the availability of quality health services; place primary health care at the centre of basic health service provision; and foster partnerships with communities and among countries.

The Government of the Republic of Zambia has been striving to respond to this international call since the early 1980s. Initially, emphasis was placed on strengthening community-level structures, which saw the establishment of Community Health Volunteers (CHV) such as Community Health Workers (CHW), Community-based Distributors (CBD) of family planning products and Traditional Birth Attendants (TBAs) (for home deliveries) as alternative vehicles for delivering health to the people. This effort was reinforced in the mid-1990s by the creation of lower-level institutional structures, such as neighbourhood health committees, that would support the initial effort and link the community structures to the traditional health system.

Inevitably, this devolution of decision-making and delivery of health care services to the lowest possible levels came with its prerequisites: institutional ownership and accountability on resources and service delivery. To this effect, the Ministry of Health (MOH) with partners have over time put in significant effort in devising frameworks through which performance could be assessed.

1.1.1 Health Sector Performance

The first notable effort at improving the health sector performance, focusing on assessing core concentration levels for health care delivery systems below the national level, was made in the mid-1990s by:

1. Transferring some powers from the central level to the lower levels of the health delivery system (namely province/region, district and facility) so that each level had authority to identify local-level problems and prioritise interventions;
2. Fostering partnership between the suppliers of health services at each level and the potential users of those services, by establishing formal institutional structures: committees for health centre level and boards for higher (districts, hospitals and national) administrative levels.
3. Developing standards and procedures to guide financial, administration and management systems. This was meant to provide a backbone for measuring health inputs and accountability towards those inputs.

[1] WHO. (1978) Declaration of Alma-Ata: *International Conference on Primary Health Care*. [Online] Switzerland: WHO Press. Available from: http://www.who.int/publications/almaata_declaration_en.pdf [Accessed 10th November 2013].

4. Simplifying and standardising performance measurement systems by designing one system for routine measurement of health and disease; developing a uniform data analysis and reporting framework for each administrative structure.

The strategies highlighted above have evolved with time whilst maintaining the core principle of assessing health inputs and outputs/outcomes. Modifications have been necessitated by adjustments to national health policies; emerging problems; improvements to data collections systems; changes to national and international protocols; and demand by some funding agencies to account for resources provided to the sector. In the process of these modifications, however, the gravity of institutionalisation of these efforts have been de-emphasised over time - leaving local-level structures to irregular and uncoordinated performance measurement undertakings.

1.1.2 Recent Effort to Support Performance Reviews

In 2007, UNICEF introduced a quarterly meeting to be conducted by each province with their respective districts to review Prevention of Mother to Child Transmission of HIV (PMTCT) indicators collected through the Health Management Information System (HMIS). To do this, a list of data elements were selected and formatted for a standard presentation template. District teams responsible for the PMTCT program were invited and assigned to prepare and make a presentation during the meeting for a specified period. The initial objective was to audit the data presented and analyse the program performance indicators in order to improve data quality based on feedback from the peers from other districts and the provincial technical team.

This innovation was then extended in some provinces (such as Southern Province) to incorporate review of other program areas such as tuberculosis (TB), HIV counselling and testing (CT), antiretroviral therapy (ART), malaria, nutrition, Expanded Programme on Immunisation (EPI), human resources for health, health care financing, and others. This again prompted for the development of a standard template to be used in all provinces. The Zambian MOH has been encouraging the provincial health managers to hold quarterly performance review meetings with their respective districts and hospitals; while at the district level, managers were also expected to organize similar quarterly meetings with managers from health facilities in their districts. These meetings are referred to as Provincial Integrated Meetings (PIM) and District Integrated Meetings (DIM), respectively. These meetings have provided a forum for obtaining feedback on health program performance indicators so that comparisons within the province in various health programs can be made, and experiences, challenges and best practices in health service delivery can also be shared.

Since 2011, the Zambia Integrated Systems Strengthening Programme (ZISSP) has provided financial and technical support to provinces to conduct review meetings as a quality improvement strategy (through the Clinical Care Specialists (CCS) seconded in each province) as part of its efforts to strengthen the health system by improving the provision of data to measure performance. This approach aimed at strengthening the capacity of the district health program officers in analysing HMIS performance indicators to identify areas of focus for quality improvement. This in turn would enhance data use for decision-making at all levels in the district.

Concerns have been raised as to the value of these review meetings because anecdotal evidence suggest that there has not been improvements reported on the effect of these meetings on quality improvement in health service delivery nor improvements in health

program indicators in any of the provinces or districts where the activity has been supported. The assumption was that there was lack of or inadequate documentation, or lack of continuity because there is usually no reference to the previous performance levels in subsequent meetings. Therefore, the format of the meetings may need to be redesigned to make them more interactive to incorporate side sessions for smaller groups.

1.2 Purpose of the Evaluation

1.2.1 Overarching purpose

The overarching purpose of this evaluation was to assess the processes, outputs and outcomes of the quarterly performance review meetings held in the provinces and make recommendations to improve the process as necessary.

1.2.2 Specific objectives

- Analyse the process, outputs, outcomes of the quarterly performance review meetings held in the provinces and document findings.
- Make consultations with the relevant stakeholders to get their views on the value of the activity.
- Propose on improvements/innovations in the approach so that it can feed into quality improvement in health service delivery with eventual and sustained improvements in identified health program indicators.

1.2.3 Evaluation Question

The major evaluation questions were the following:

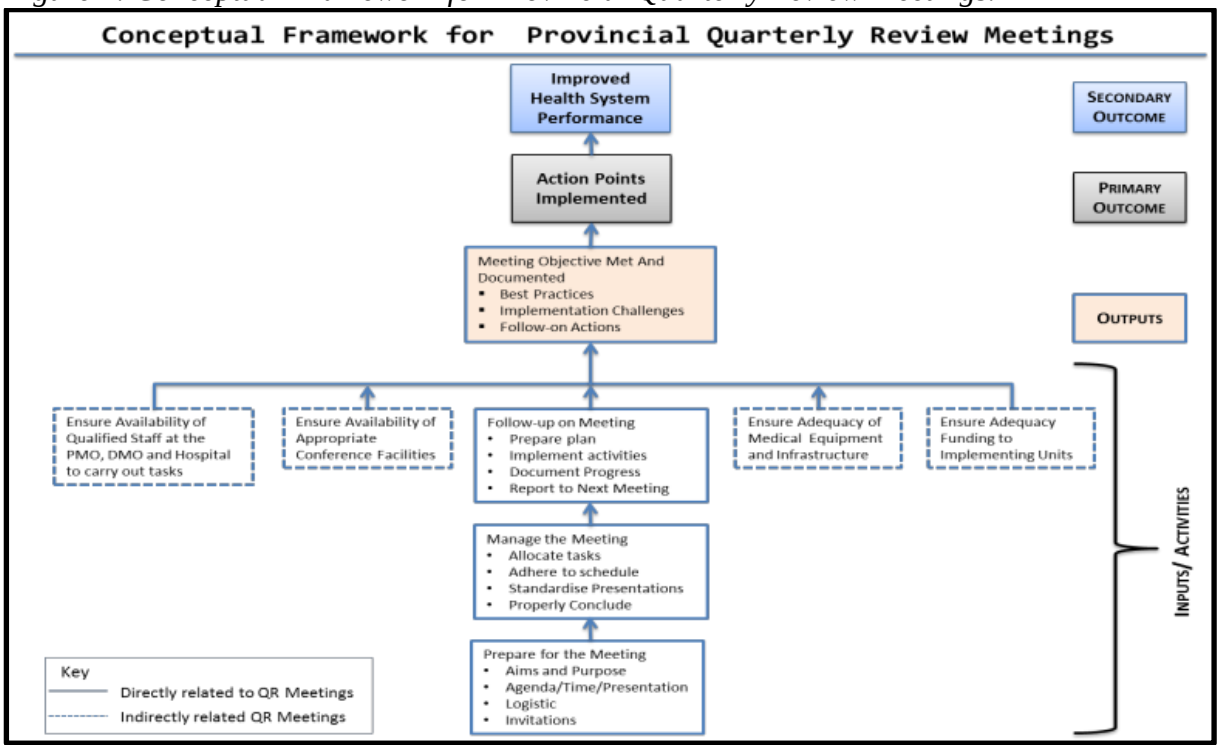
1. What things are considered prior to the meetings in terms of participants, minutes of the previous meetings, agenda, purpose and expected outcomes?
2. How are participants involved in the preparation of the meetings, expected roles, presentation, and specific topics/templates to guide the presentations?
3. How are meeting conducted in terms of timing, agenda followed, key facilitators, minutes followed, etc.?
4. What is used to guide the meeting, presentations?

2 METHODS AND LIMITATIONS

2.1 Evaluation Framework

The evaluation approach was based on the understanding that provincial performance review meetings are organised regularly with the view of improving the provincial health service delivery outcomes and ultimately the national health indicators. To achieve this, a standard list of indicators has been selected upon which various levels of administration and care meet to compare their performance, share experiences and challenges, then make appropriate recommendations for improvement. However, these quarterly review meetings are not the ultimate solution in themselves; careful preparation and post-meeting follow-up provide the backbone to the overall success. Figure 1 below attempts to summarise what is expected from provinces in order to attain the desired goal – improved health performance. This scheme was used to guide the evaluation process.

Figure 1: Conceptual Framework for Provincial Quarterly Review Meetings.



2.2 Methods of Data Collection

Three methods of data collection were used in this evaluation: review of quarterly performance review meeting reports, one-on-one structured interviews with key informants, and a self-administered questionnaire to obtain opinions from participants' on the relevance and quality of quarterly performance review meetings. **Annex 1** includes additional information and details on each of the data collection methods and what question each tool contributed to in the evaluation**.**

1. Review of Previous Meetings' Reports and Presentations: At the inception of the study, two types of reports were reviewed: the provincial team reports and summarised trip reports prepared by ZISSP staff at the end of each meeting. In

addition to the reports, quarterly performance review presentations used during any of the previous provincial meeting were also reviewed.

To assess the quality of reports from the previous meetings, a template was developed which focused on the following: Report Format; Clarity of Aims and Purpose; Discussion; Conclusion/Recommendations.

2. Key Informant Interview (KII): An interview guide was developed to collect qualitative information regarding the practice during planning for the meeting, conducting the meeting and follow-up on the recommendations made thereof. Besides the separate notes that each interviewer took during the interviews, each interview was also digitally recorded on voice recorder for further transcription.

3. Self-administered questionnaire: This schedule was a standardised set of responses on a 9-point[2] Likert Scale around core stages of meeting preparations, execution and follow up.

2.2.1 Sample distribution

Provinces and districts covered by this evaluation were distributed by assessment approach as follows:

Data Collection Method	Units per Province	Total Sample
Key Informant Interview (KII) – one-on-one	Copperbelt (7); Eastern (7); Southern (5)	19 KII
Self-administered (opinion) interview	Copperbelt (14); Eastern (10); Southern (14); Others (7)	41 interviews
Review of reports	Central (2); Eastern (2); Northern (2); Southern (1) and; Western (2).	9 reports

a) One-on-one KII

ZISSP, in consultation with the MOH, selected three provinces (Eastern, Copperbelt and Southern) in which to conduct face-to-face interviews. This selection was premised on the understanding that Eastern Province was one of the provinces known to consistently hold the meetings, while the other two provinces were chosen because they were once ZISSP-funded and were the closest to visit within the allocated time and budget. A total of 19 interviews were conducted from the three provinces.

b) Self-administered interview (opinions)

The primary focus provinces for this interview were the same three provinces were KII one-on-one interviewed were conducted. However, after returning from the field, the evaluation team took advantage of the presence of ZISSP staff (Management Specialists and CCSs)

[2] An odd number "9" was chosen so that the scale as an intrinsic neutral opinion – the mid-point

from other provinces that were attending a meeting in Lusaka and administered an extra seven questionnaires – bringing the total number of respondents to 41.

c) Review of Reports

For the purpose of detailed review of previous performance review reports and other related documentation, the study targeted three most recent reports from each of the nine provinces[3]. However, it was not possible to access all the 27 reports. There was no report made available from Copperbelt, Lusaka, Luapula and North-Western Provinces; the reports that were available in most instances were trip reports prepared by ZISSP-seconded CCSs, which were too summarised for use in this study. Out of the targeted 27 reports, a total of nine reports were accessed and reviewed, covering five provinces as follows: Central (2); Eastern (2); Northern (2); Southern (1); and Western (2).

2.2.2 Respondents

The study targeted two sets of respondents to provide information on the practice and perceptions on quality and value of quarterly performance review meetings. Below is the list of positions for both interviews (for a detailed list, see Annex 7):

- Provincial Medical Office: For both interviews, the targeted respondents included the Provincial Medical Officer, two CCS; the ZISSP Management Specialist, Provincial Planner and Senior Health Information Officer. For any other staff member who reported having attended at least one meeting, only the questionnaire on perceptions was administered to them.
- District Medical Office: The main target for the one-on-one interview and the perception questionnaire included the District Medical Officer, Senior Clinical Care Officer, District Health Information Officer, District Planner and any other technical staff reported to have attended at least one quarterly performance review meeting or participated in preparing for it.
- Level 2 and 3 Hospitals: At the hospital, the Medical Superintendent, the Head-Clinical Care, Nursing Officer and Senior Health Information Officers are the usual invitees to the meeting and were identified as core staff in preparing for the same meetings. As such, they were selected by default for inclusion in both interviews.

2.3 Data Processing and Analysis

Since this evaluation used both qualitative and quantitative data collection methods, the following two separate methods were equally used to process and analyse the data:

- One-on-one KII: At the end of each interview day, the interviewer listened to the recording and reinforced the notes that would have been taken under each respective question. For each interviewee, a separate questionnaire was used to note the discussions under each question. At the end of the fieldwork, the three teams from each of the provinces visited held a one-day meeting to discuss the findings. All the 19 interviews

[3] Not including Muchinga, the 10th province that was recently created.

were reviewed for clarity, and key points from each respondent were summarised onto one questionnaire – question by question.

- Self-administered Likert-Scaled Interview: Data entry and processing was done using SPSS. The measurement scale was originally ordinal, but this was converted to dummy interval scale for purpose of running measures of central tendency and dispersion. For each evaluation statement, a mean score and a corresponding standard deviation were computed.
- Review of Reports: To assess the quality of reports from the previous meetings, a template was developed which focused on the following: structure and format; *clarity of* purpose and aims; *relevance of* discussion *and how this links into* conclusions and recommendations.

2.4 Limitations

This evaluation was not without challenges. Below is a summary of some of these limitations encountered before, during and after the fieldwork:

- **Recall lapses:** Except for Eastern Province, the other two provinces visited had not been consistent in holding their quarterly performance review meetings. On the Copperbelt, for example, these meetings had only been held twice since 2011: focusing on quarter two of 2011 and 2012, respectively. It was difficult for most respondents to spontaneously remember the meetings the evaluation was targeting. The consolation however (at least as it pertains to the processes) is that meetings held at this level were traditionally organised the same way. Weaknesses or strengths observed may not be unique to performance review meetings only, but are likely to affect any other meetings organised by the Provincial Medical Office for its districts, hospitals and training institutions.

- **Deficiency of Record Keeping/Filing:** Some institutions could not avail to the evaluation team the quarterly reports and presentation templates that were required: Either the person who the office believed had the documents was not in office, or the offices (hospital, district or provinces) could not locate the files (soft or hard copies). Institutions that were able to avail the evaluation team with some templates and reports did so after a long search – making it difficult for the team to discuss the contents of those documents onsite.

3 FINDINGS

The main findings are grouped according to meeting inputs/processes; outputs of the meeting; and post-meeting follow-ups and outcomes. In the following sections, average perception scores are provided in parentheses for selected topics. A Likert scale of 1 to 9 was used for this analysis, with higher scores (closer to 9) indicating the respondents strongly agreed with an attribute and lower scores (closer to 1) indicating that respondents strongly disagree with an attribute. Findings from the opinion scores are compared and contrasted with those of the one-on-one key informant interview and from the review of quarterly reports.

3.1 Processes in Organising Meetings

The effectiveness of any meeting starts with how much effort goes into its preparation. The following three summary aspects (agreed between ZISSP and the evaluation team) qualified a meeting to be successful: achieving the meeting's objective; spending a minimum amount of time to run the meeting; and ensuring that the expectations of the participants have been adequately addressed. To achieve this, proper planning before the meeting takes place was necessary. This section attempts to present findings covering the steps taken to prepare for the meetings and how the proceedings of meeting were managed.

On a scale of 1 to 9, respondents felt that key decisions intended for the meeting were usually discussed among key provincial staff (7.40) and generally understood amongst themselves before the meeting (7.03). Once this was done, presentation templates would then be circulated in good time (typically 6-8 weeks before the meeting) for the institutions to prepare their presentations (7.05). From the three provinces visited (Southern, Eastern and Copperbelt), the invitations were reported to be sent between 7 and 14 days before the meeting (**Table 1**).

Table 1: Perception about the practice of conceiving and communicating the aims and purpose of the meeting to the participants

		Eastern (n=9)	Copperbelt (n=13)	Southern (n=9)	All Others (n=7)	Total (n=38)
		Mean score (Standard Deviation)				
1	Key decisions and actions to be made at the meeting are discussed among PMO staff before communicating to districts and hospitals	8.11 (1.36)	7.17 (2.52)	7.29 (2.29)	7.00 (1.63)	**7.40** (2.02)
2	Key decisions to be made in the meeting are well understood by key PMO staff before the meeting	7.44 (.73)	7.00 (2.52)	7.29 (2.29)	6.29 (1.98)	**7.03** (1.99)
3	Key decisions that should be made at the meeting are communicated before the meeting takes place	5.11 (2.80)	6.42 (2.27)	5.71 (3.15)	5.86 (2.27)	**5.83** (2.54)
4	Meeting notifications are sent to the districts and hospitals in goodtime for them to prepare their presentations	7.78 (2.22)	7.69 (1.32)	6.00 (2.60)	6.29 (2.69)	**7.05** (2.22)
5	Notifications sent to participants are always accompanied by a timetable	4.89 (2.47)	5.38 (3.25)	6.00 (3.02)	4.71 (2.21)	**5.27** (2.78)
6	Notifications provide enough information on what districts and provinces are expected to do to prepare for the meeting	8.25 (1.16)	8.08 (1.44)	6.67 (2.18)	6.00 (2.90)	**7.42** (2.02)

From the one-one-interview it was learnt that preparation of the agenda (or timetable) was done by the Provincial Medical Offices and, once completed, copies were either made available before the meeting (Eastern) or seen by the participants during the meeting (Southern and Copperbelt). In either situation, on the day of the meeting, participants were taken through the schedule for purposes of familiarisation and not for the participants to provide input - either at the start of the meeting (5.83), or before the meeting (4.90).

The presentation templates and contents of the letters of invitation were deemed adequate (7.42) to enable them prepare for the meeting and were considered as the most important pre-meeting piece of required information, followed by the list of positions on who should attend the meeting. They felt there was a need to improve on the clarity of anticipated outcomes from the meeting (5.83) and accompany meeting notifications with a timetable (5.27) at all times.

The evaluation reviewed the presentation templates that were used during the most recent meetings for content and consistency. Within each province, these PowerPoint presentations were generally standardised (with similar indicators for each level), but variations were observed across provinces; Eastern Province had an additional template for training institutions which was not seen in Copperbelt and Southern Provinces.

According to the respondents, the agenda of the meeting was presented to them in the form of a timetable with timeslots allocated for each activity (7.40) with clear roles and responsibilities (8.0) for each activity on the meeting schedule. However, minutes or reports from the previous meeting were not generally made available to participants to refresh them on the action points (4.88) (**Table 2**). From the one-on-one interviews, respondents reported that presentations from each district and hospital included a slide on action points from the previous meeting and the progress thus far. This was confirmed through the review of the presentation template. However, the concern expressed was there that was not enough time allocated to this point– Copperbelt reported that they were given 10 minutes per presentation (including action points) to cater for the many districts, hospitals and training institutions in the province.

Table 2: Perception about the Practice towards Preparing the Meeting Agenda/Timetable and Circulating to the Participants

		Eastern (n=10)	Copperbelt (n=13)	Southern (n=10)	All Others (n=7)	Total (n=40)
		Mean score (Standard Deviation)				
1	Minutes reports from the previous review meetings are circulated in good time before the next meeting	7.40 (0.97)	4.54 (3.02)	3.40 (1.35)	4.00 (0.82)	**4.88** (2.43)
2	Meetings always have an agenda	7.00 (3.20)	8.77 (0.60)	7.20 (2.25)	7.14 (1.77)	**7.65** (2.18)
3	Agenda items are clearly presented in a timetable and activities can be linked to the expected meeting outcome	6.90 (2.92)	8.46 (1.05)	7.30 (1.83)	6.29 (2.36)	**7.40** (2.15)
4	The meeting timetable outlines the time each task will be done with clear roles and responsibilities	8.90 (0.32)	8.54 (0.78)	7.10 (1.97)	7.00 (2.16)	**8.00** (1.59)

On the purpose and aims of the meeting, participants felt that key decisions intended to be made at the meeting were not usually made known to the participants before the day of the meeting (5.83) (Table 1, #3, above). Eastern Province might be an exception to this weakness, as confirmed by Tables 2 and 8. According to the key informants interviewed from Eastern Province, the purpose and aim were reportedly clear and usually circulated before the meeting, although the timing for circulating the agenda did not appear to be standardised. This was confirmed by reports reviewed for Eastern Province in which it was noted that, at the beginning of each meeting, the Provincial Medical Officer (PMO) gave an opening speech that clearly set the tone and expectations of the meeting. Quoting in part from the 2012 4th quarter report, this is what the PMO said: "*the meeting once again has given us an opportunity to take stock of performance……. I commend all of you for your efforts in the health sector……. However this is no time to relax as there remains a lot of unfinished business and it is my sincere hope that as we compare notes in this meeting, 2013 will be a better year."*

However, reviews of reports from provinces revealed that the inclusion of objectives in the reports was optional. Most reports (including Eastern Province) did not list objectives at the beginning of the report; instead they went straight into discussing the proceedings of the meeting without listing their objectives. This evaluation expected that the timetable for meeting would be appended to the report so that proceedings of the meeting could be associated to the objectives (where they were available). However, this was not the case for most of the reports.

Key informants were asked if the venue, timing and scheduling of the meeting were convenient to both the province and institutions. All three provinces felt they organised their meetings according to general expectations; with Copperbelt province (min=7.15, max=8.43) with the highest score, followed by Southern (min=6.90, max=7.90) then Eastern Province (min=5.70, max=7.20) (**Table 3**). On the convenience of the timing of the meetings, key informants from the one-on-one interview from Eastern Province did not think the dates were usually convenient; at times the dates picked for the meeting by the provincial management coincided with other programme activities in the districts. Timing and scheduling did not appear to be issues of concern to Copperbelt and Southern provinces.

Table 3: Perception about the Practice towards Timing and Scheduling of Meetings by Provincial Medical Offices

		Eastern (n=10)	Copperbelt (n=14)	Southern (n=10)	All Others (n=7)	Total (n=41)
		Mean score (Standard Deviation)				
1	The timing (dates and time) of the meetings are usually convenient for both the organisers and the participants	5.70 (2.58)	7.15 (1.57)	6.90 (1.91)	5.57 (2.23)	**6.45** (2.10)
2	The venues selected for the meetings are usually the best options available	7.10 (1.97)	8.36 (1.01)	6.60 (1.65)	5.57 (1.99)	**7.15** (1.85)
3	The conference rooms hired for the meetings are usually well arranged so that all participants are able to see each other	6.20 (2.04)	8.29 (0.99)	7.60 (1.07)	6.57 (1.40)	**7.32** (1.60)
4	The conference rooms hired for the meetings are usually well arranged so that all participants are able to hear each other	7.20 (1.81)	8.43 (0.85)	7.90 (1.37)	6.71 (1.38)	**7.71** (1.45)

Opinions on the appropriateness of the presentations revealed that there was adherence to expectations in preparing for the meetings. Respondents from all provinces strongly agreed that a format to guide institutional presentations existed (8.1) with a standard set of indicators (8.0) for each category of institutions and that institutions generally adhered to the specifications of these templates (7.4) (**Table 4**). However, provincial variations were noted: Respondents from Eastern Province felt more strongly that participants adhered to the format of the template and its intended use compared to those from Southern Province. When asked which of the materials circulated to the meeting participants were found most useful, the presentation template was picked out to be the most helpful in fulfilling the aim of the meeting.

Table 4: Perception on the format of presentations used by district and hospitals for the meeting

		Eastern (n=10)	Copperbelt (n=14)	Southern (n=10)	All Others (n=7)	Total (n=41)
		Mean score (Standard Deviation)				
1	A standard template to guide presentations is circulated to districts and hospital beforehand	8.60 (0.97)	8.77 (0.44)	6.20 (2.62)	6.29 (2.75)	**7.65** (2.13)
2	Districts' and hospitals' presentations strictly adhere to the specifications of the standard template	8.60 (0.70)	7.85 (1.14)	6.80 (2.39)	5.57 (2.15)	**7.37** (1.92)
3	Presentations from all districts are on the same topics indicators	8.90 (0.32)	8.86 (0.53)	7.20 (2.39)	6.86 (2.19)	**8.12** (1.72)
4	Presentations from all hospitals are on the same topics indicators	8.80 (0.42)	8.85 (0.55)	7.20 (2.39)	6.57 (2.44)	**8.02** (1.82)
5	Presentations from districts and hospitals are clear on achievements, challenges and recommendations	8.10 (1.20)	8.43 (0.76)	7.90 (0.88)	6.86 (1.57)	**7.95** (1.16)

For a meeting to be successful, it is important for the starting point to be well managed. Considerations at the start of the meeting should address the following questions: Are the start time and end times known in advance?; Is the timing of meeting items well-known to the participants?; Have the organisers ensured that every participant has a role to play during the meeting?; Is the meeting timetable well-understood by everyone in as much as attaining the meeting objectives was concerned?[4]. It was clear from the respondents' experiences that it was not a standard practice for participants to be on time on the first day (6.51); start the meeting on time on the first day (6.07); to be given an opportunity to review the agenda (5.83) nor did they strongly feel that people chosen to record proceedings of the meetings were usually the best persons for the assignment (6.63) (**Table 5**). Although it is expected as a good practice that facilitators and moderators know that they have these responsibilities in advance, it appeared these were only made known to them on the first day of the meeting (7.50). Concerning starting on time on the first day, during the one-on-one interviews with informants from Luanshya District Health Office reported that this was a challenge due to proximity of towns (some participants chose to check into the venue on the morning of the meeting, thereby delaying the start time).

[4] Ibid

Table 5: Perception on how meetings are managed on the first day

		Eastern (n=10)	Copperbelt (n=14)	Southern (n=10)	All Others (n=7)	Total (n=41)
		Mean score (Standard Deviation)				
1	Invited participants are usually on time on the first day of the meeting	7.60 (0.84)	6.64 (1.65)	5.80 (1.99)	5.71 (1.60)	6.51 (1.69)
2	Meetings usually start on time on the first days	6.70 (2.36)	5.93 (2.09)	5.60 (2.01)	6.14 (2.19)	6.07 (2.11)
3	Participants are usually given an opportunity to review the agenda timetable	5.00 (2.67)	6.14 (2.51)	6.40 (2.01)	5.57 (1.62)	5.83 (2.29)
4	Responsible persons for each task on the timetable are usually known on the first day	7.10 (2.13)	8.14 (1.46)	7.44 (1.94)	6.86 (1.77)	7.50 (1.81)
5	People chosen to chair the meeting sessions are usually the best persons for the task	7.40 (1.35)	7.00 (1.71)	6.80 (1.69)	6.00 (1.41)	6.88 (1.58)
6	People chosen to take notes during the meeting are usually the best persons for the task	7.40 (2.27)	6.85 (2.03)	6.40 (1.35)	5.43 (1.72)	6.63 (1.94)

Table 6 presents the strength of opinions of respondents on selected principles of good facilitation and participation. Respondents from Eastern Province did not strongly feel that these were put to practice. In Southern and Copperbelt Provinces they felt that review of previous days' proceedings (8.10) and refocusing of deliberations when strayed from the agenda items (8.14), respectively, were put into practice. It was less likely for Eastern Province to review previous days' proceedings (6.00), ensure participation from everyone (6.30), ensure continuous participation from everyone throughout the meeting (6.2) and keep the meeting focussed on the agenda items (7.10) than the other two provinces visited. Some of the problems cited by key informants for non-adherence to the meeting schedule included the loss of time in waiting for the official opening (and sometimes the press) and not having enough time allocated to presentations because of the many institutions and facilities invited. Because of this, districts, hospital and training institutions were at times made to rush through their presentations (Copperbelt). The Provincial Medical Officer from Eastern Province attributed improvements in adherence to the schedule to the fact that he was present throughout the meeting and the province had cut down on the number of participants invited to the meeting.

Table 6: Perception on how meeting organisers facilitate the meeting and encourage participation from participants

		Eastern (n=10)	Copperbelt (n=14)	Southern (n=10)	All Others (n=7)	Total (n=41)
		Mean score (Standard Deviation)				
1	Proceedings of the previous day are reviewed at the beginning of each following day	6.00 (2.54)	6.93 (2.34)	8.10 (0.99)	7.14 (1.86)	**7.02** (2.13)
2	Invited participants consistently attend the meeting from first to the last day	6.20 (2.62)	7.00 (2.08)	7.40 (1.07)	5.71 (1.38)	**6.68** (1.97)
3	All participants actively take part in deliberations of the meeting	6.30 (1.64)	7.00 (1.57)	7.30 (1.49)	6.57 (1.51)	**6.83** (1.55)
4	Facilitators adequately preside over the meetings in as much as managing dominant participants and encouraging the quiet ones	6.70 (2.21)	6.57 (2.41)	7.10 (1.29)	6.29 (1.60)	**6.68** (1.95)
5	When discussions during the meeting stray from agenda items facilitators are usually able to refocus the meeting to its aim.	7.10 (2.02)	8.14 (0.86)	7.70 (1.25)	6.57 (1.27)	**7.51** (1.45)

3.2 Outputs of the Meetings

Once the meeting outcome has been clearly defined and the roadmap to achieving it is known and shared among stakeholders, it expected that inputs, processes and the intended outcomes beyond the meeting are all well-documented. This documentation can be either in a form of minutes or a report, depending on the existing protocols. This section presents information on the practice that existed in documenting meeting proceedings and what the final outputs of the meetings were. The three final outputs considered are the following: report and minutes (and whether they are circulated on time); clearly outlined action points; and the tentative schedule of the next review meeting.

Table 7 presents three core attributes for a successful meeting: summarising key decisions and action points; end-of-meeting evaluation; and agreeing on the tentative agenda for the next meeting. Except for summarising key decisions and actions points from the meeting (7.78), discussing and agreeing on a tentative agenda for the next meeting (4.90) and end-of-meeting evaluation (4.32) did not seem to be observed. It is a good practice that, at the end of the meeting, organisers solicit for feedback on how well the meeting was executed and agree on the tentative date and agenda for the next meeting. However, it appeared that this was not done most of the time in all provinces, as shown by the low scores of 4.90 and 4.32 for the agenda and meeting evaluation respectively. From the discussions with key informants, it appeared that summaries were made at the end of meeting, and a list of agreed-upon action points were drawn and usually circulated right before the end of the meeting, later followed up with a report (Eastern Province).

Table 7: Perception On How the Facilitators and Participants Conclude the Meeting

		Eastern (n=10)	Copperbelt (n=14)	Southern (n=10)	All Others (n=7)	Total (n=41)
		Mean score (Standard Deviation)				
1	At the end of the meeting all key decisions and action points reached are well-documented and understood by all participants	8.50 (0.53)	7.50 (2.38)	7.90 (0.88)	7.14 (1.35)	**7.78** (1.60)
2	At the end of the meeting, participants discuss and agree on the tentative agenda for the next quarterly review meeting	4.50 (3.17)	4.64 (3.32)	5.60 (2.91)	5.00 (1.53)	**4.90** (2.88)
3	A meeting evaluation is done using a standard checklist format	3.10 (2.28)	4.43 (2.87)	5.90 (2.56)	3.57 (2.15)	**4.32** (2.67)

Although key decisions and action points were reportedly well-documented and understood by the participants (7.78) (see Table 7, #1, above), Table 8 shows that meeting reports were not circulated on time (4.68); even when circulated, it was rare that every participant from the meeting would receive a personal copy of the report (4.20). Respondents were not certain whether any official report outline from the MOH actually existed (5.44). However, whatever format was used, in their opinion, it was possible to pick what was agreed to be done, the timelines and responsibilities from the report (6.82). However, from the information collected during one-on-one interviews with informants from Copperbelt, it was clear that for the two meetings that had been held in the province, participants had not seen the reports.

Table 8: Perception on the Practice towards following up on the Deliberations of the Meeting

		Eastern (n=10)	Copperbelt (n=14)	Southern (n=10)	All Others (n=7)	Total (n=41)
		Mean score (Standard Deviation)				
1	A meeting report is received within two weeks after ending the meeting.	6.60 (2.50)	4.50 (3.28)	3.80 (2.35)	3.57 (2.15)	4.68 (2.86)
2	Every participant receives a copy of the report	6.70 (2.50)	3.07 (2.79)	3.10 (2.33)	4.43 (2.82)	4.20 (2.94)
3	Reports are written using a standard report outline	6.00 (3.65)	5.29 (3.22)	4.70 (3.06)	6.00 (2.58)	5.44 (3.12)
4	It is easy to pick from the reports key decision points, actions required, timing, roles and responsibilities for implementing them	8.00 (1.15)	6.08 (3.00)	6.80 (2.25)	6.43 (1.99)	6.82 (2.30)
5	Actionable points from the meeting are usually followed up	7.10 (2.33)	6.79 (2.04)	5.90 (2.56)	4.86 (1.35)	6.32 (2.23)
6	There is evidence from the past meetings whereby a recommendation was used to improved quality of care	7.60 (1.43)	7.23 (2.39)	5.70 (2.79)	5.86 (2.19)	6.70 (2.33)

A total of nine reports from past quarterly review meetings, covering five provinces, were reviewed on the following attributes: structure and format; *clarity of* purpose and aims; *relevance of* discussion *and how this link into* conclusions and recommendations. Below is a summary of findings around these attributes.

- Structure/Format: Given the importance attached to this meeting, it was surprising that a standard report outline had not been developed by the MOH for all the provinces to use. Each province, with variations within, seemed to have had its own approach to organising the meetings and subsequently the meeting report thereof.
- Purpose and Aims: The general observation across reports on the subject was that it was difficult to tell whether the meeting objectives (some reports had no objectives) had actually been met by the meeting. This problem arose from the fact that, despite listing the objectives, contents of the reports were not linked to the objectives – the reader had to match the individual sentences in the report to a specific objective.
- Discussion: Discussions were quite detailed and revealing in a number of reports, while others were too brief to be useful. The general observation was that in some reports, concerns/issues raised were not linked to earlier discussions or data. This problem was also observed where recommendations were not related to the topics under discussion.
- Conclusions and Recommendations: This section in most of the reports was marked "Action Points" and were generally detailed. However, due to limited information in the discussion section of the report – the basis on which recommendations should have been made, a number of action points could not be related to any discussion (achievements or constraints) from the earlier part of the report.

3.3 Outcomes of the Meetings and Follow-ups

The ultimate intention of these review meetings is to identify health service delivery gaps for quality improvement. Once action points have been agreed upon during the meeting, documented and made available to service providers, the province or districts are expected to make follow ups to ensure that the resolutions are implemented. On the other hand, institutions are equally expected to periodically provide information on the progress made

thus far. The evaluation collected information on whether action points from meetings were followed up with action and if progress on these action points were discussed in successive meetings or at the end of the year.

Formulation of action points are part of the most important outputs of quarterly review meetings. However, respondents did not think this was the case much of the time. From the three provinces visited, action points were believed to be least followed up in Southern Province (5.90) and most attended to in Eastern Province (7.10); the perception is the same as regards the application of recommendations to improving quality of care and service delivery with scores of 5.70 and 7.60 for Southern and Eastern Provinces, respectively. Nonetheless, isolated examples were cited by the following institutions[5], whereby recommendations from the meetings were used to improve care and quality of services:

- Ronald Ross Hospital: Still births were noted to be high during one of the meetings. After the meeting, the hospital did its investigation and confirmed that indeed fresh still births were high and this was due to old and defective equipment. The hospital has since worked with the province to order new equipment.
- Ndola District Medical Office: Lack of feedback on referrals was identified as a problem between health centres and Ndola Central and Arthur Davison hospitals. Following a series of meetings, feedback mechanisms were put in place that have improved health service delivery. Clerks from the district regularly visit the two hospitals to collect referral forms for all patients that were referred and discharged. These forms are taken back and filed at the referring health facility.
- Eastern Province: In one meeting it was observed that the incidence of dysentery had increased. A resolution was passed that all cases should be confirmed by laboratory tests. This saw a reduction in the cases reported.

Despite varying challenges faced by provinces and institutions in planning, implementing, and following up on resolutions from these review meetings, respondents strongly disagreed (1.05) with the proposal to discontinue the performance review meetings (**Table 9**). However, they proposed that improvement be made to the proceedings of the meetings. In their opinion the most important aspect that would need improvement was strengthening follow up (8.61), followed by the process of organising the meetings (7.63), content and quality of the presentations (7.44) and clarity on the aims and purpose of these meetings (7.28).

[5] These reports were not independently verified by the evaluation team as none of the cited experiences were part of the reports that were reviewed. It is possible this was done but not documented.

Table 9: Perception On What Should be Done to the Quarterly Review Meetings in Future

		Eastern (n=10)	Copperbelt (n=14)	Southern (n=10)	All Others (n=7)	Total (n=41)
		Mean score (Standard Deviation)				
1	Quarterly review meetings should continue the same way they are being done currently	7.22 (2.82)	5.77 (2.77)	5.22 (3.46)	5.00 (3.16)	**5.84** (3.02)
2	Quarterly review meetings should continue but there is need to clarify what they are meant to achieve.	5.89 (3.30)	7.71 (2.43)	7.44 (2.55)	8.00 (1.00)	**7.28** (2.54)
3	Quarterly review meetings should continue but there is need to improve on how they are organised	6.40 (2.80)	8.23 (1.36)	7.88 (1.36)	8.00 (1.15)	**7.63** (1.91)
4	Quarterly review meetings should continue but there is need to improve on the content and quality of presentations	6.90 (2.60)	7.62 (2.14)	8.22 (1.09)	6.86 (2.91)	**7.44** (2.22)
5	Quarterly review meetings should continue but there is need to strengthen follow up	8.40 (1.26)	8.79 (0.58)	8.70 (0.48)	8.43 (0.79)	**8.61** (0.80)
6	Quarterly review meetings should not continue	1.00 (.00)	1.00 (.00)	1.00 (.00)	1.29 (0.76)	**1.05** (0.32)

4 CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusions

4.1.1 Processes in Organising Meetings

From the information gathered through the review of the previous meetings' reports and the responses from key informants, it was clear that the formulation of meeting objectives had been treated as a routine procedure whereby the list of objectives was generally standard across meetings; what only changed were the reference points (quarter and year). The general context of objectives reviewed from the reports was to review progress, share experiences and formulate solutions. However, there was no standard continuum against which to compare institutions.

Preparation of the agenda was generally done by the Provincial Medical Office only. From the reports reviewed, objectives of the meetings rarely changed across meetings and because of that, the timetable was usually the same from meeting to meeting.

Based on the presentation templates and reports reviewed, it appeared once the template was released to the provinces, the rights of making future changes to the content and style was not reserved by the original authors. Provinces are currently free to make changes to the original content; which would make it difficult to extract information when the need to create a national profile arose.

Although notices were generally sent on time, it was reported that there were instances when some institutions were not ready for the meeting. For example, at times participants would be seen in the conference room trying to finish up their presentations, and sometimes institutions would be represented by an incomplete team on the first day because other team members were still at the institution finalising the presentation.

Reading the reports and reviewing the templates suggest that objectives for the meeting were phrased to meet the structure of the presentation template – which focused mainly on the review of progress. Much as the presentations may have been adequate in themselves in addressing this objective, the objectives as phrased in most of the reports lacked clarity. Reporting on progress had generally been approached through the listing of indicators according to time point so as to show whether there was an upward, static, downward or an unstable trend. This alone was not helpful, as an indicator could be going up but it was still below expectations.

Ensuring that meetings start on time every day is the responsibility of senior management at the Provincial Medical Office. For this reason, some provinces were doing well in this aspect while others were not[6]. This problem can be partly resolved by ensuring that (a) objectives are shared by both parties and (b) that the starting time on the timetable takes cognisance of other factors (such as lodging arrangements and efficiency of dining facilities at the meeting venue). Consistent presence of senior Provincial Medical Office staff in the meeting would help on this aspect. On how to prepare the agenda and manage the resulting timetable during the meeting, this will require some improvement.

Effective meetings can be summarised around three things: achieving meeting's objective, taking up a minimum amount of time, and ultimately leaving participants feeling satisfied. Although respondents did not look at time management as a big problem, there are isolated examples from this evaluation that suggest that at times this factor can be a very big problem. For example, from one report in Northern Province, the meeting extended outside conventional office hours in Zambia (starting at 8:50, with lunch at 13:30, and ending at 17:40).

4.1.2 Outputs of Meeting

The evaluation observed some weaknesses in how meetings were concluded, how proceedings were documented and disseminated. Firstly, there did not appear to be a deliberate system in place for the organisers to obtain feedback on how well the meeting was handled (so that improvements could be made in future). Secondly, there was inadequate or lack of documentation of the meeting proceedings, and the quality of some reports was not acceptable.

4.1.3 Outcomes of the Meeting

It was clear from the findings that provincial offices with their institutions were aware that the final outcome of the meeting was to improve care and quality of services; this is evident from the fact that nearly all the reports reviewed had action points formulated on the basis of some identified challenges that were presented during the meeting. However, the implementation framework for those action points was not clear. The needed link between the revision of action plans and newly identified problems through review meetings is not clear.

[6] This evaluation question does not therefore attract a recommendation.

4.2 Recommendations

4.2.1 Processes in Organising Meetings

1. Since much of the time of these meetings was spent on presentations by participants on their progress, it is imperative that the national level standardise the presentations outline and develop thresholds and targets for all the indicators against which progress should be assessed during the meetings. See **Annex 2** for a proposed outline.

2. To make quarterly review meetings more dynamic and participatory, organisers should consider the following:

    a) During the preceding meeting, participants should be given an opportunity to contribute agenda items to the next meeting. These items could be from a list of issues raised during that meeting but could not the resolved right away. See *Annex 2: Table 3b* and *Table 3c*.
    b) At the end of each meeting, the provincial team with participants should pick areas of focus for the next meeting. These themes would then demand for a detailed analysis and discussion during the upcoming meeting. See *Annex 2*: Step 4 (i) and *Table 4*.

3. Standardising presentations for similar type of institutions within a province has been a tremendous effort towards improving the quality of presentations and improving the efficiency of meetings. To enhance these achievements, the following should be considered:

    a) The Directorate of Technical Services at the MOH, with input from other directorates, should develop a national template which all provinces should use, with flexibility for each level to include additional slides for presenting on local level peculiarities. See *Annexes 2 and 3* for a proposed set of tables and presentation formats.

    b) All the tables and slide proposed in *Annexes 2 and 3* should be accompanied by a set of instructions on what is expected on that slide/table. This will even enforce further the intended objective through standardisation.

4. To ensure that performance review meetings are convenient and consequently beneficial to both parties, all relevant institutions should include review meetings in their action plans. The province should provide flexible set of dates during the year around which institutions should plan. (Currently these meetings are ad hoc.)

The MOH should consider adjusting the approach to preparing the presentation slides which will ultimately determine how the presentations would be done and what the report will look like. Below are some things that should be considered:

5. Once the reports have been prepared by the districts, hospitals and training institutions, during the meeting these reports should be peer-reviewed by thematic experts. For details, see *Annexes 2* and *3:* "Presentation Stage" for a proposed approach.

6. After presentations (by thematic area) have been reviewed during side session (*Annex 2*: *Step 6*), presentations would be made according to programme areas. This recommendation is likely to resolve the problem of monotony arising from institutions circling through similar content.

7. Going beyond the allocated time is as a result of two things: unrealistic timetable and inadequate facilitation skills. It is important that the timetable is discussed in detail before the meeting and reviewed at the start of the meeting.

8. The Provincial Medical Office should always prepare a brief that addresses all common issues that may arise from the presentations that require feedback from the province. These can be addressed in one presentation by the province at the beginning of the meeting so that the meeting is not derailed by discussing side-issues inside a presentation (see *Annex 3: Step 3).*

4.2.2 Outputs of the Meetings

1. A standard format should be developed which all provinces should be expected to complete for future improvements to the meetings. This can be developed centrally and distributed to the provinces. See *Annex 4* for a sample.

2. To improve on documentation, the Directorate of Technical Services in the MOH, in consultation with provinces, should:
   a) Consider developing a template to assist provinces in organising their notes during the meeting. See *Annex 5* for a sample.
   b) Develop a standard report outline which all provinces should follow, taking into account other recommendations, such as aligning presentations around thematic areas as opposed to institutions. See *Annex 6* for an outline[7].

4.2.3 Outcomes of the Meetings

1. To improve the follow up on action points from the meetings, the approach, content of the presentations, and the organisation may require some restructuring. For a summary on the proposed implementation steps, refer to *Annexes 2 and 3*.

5 FOLLOW UP ACTIVITIES/NEXT STEPS

From this evaluation, it is clear that quarterly review meetings are highly valued by provinces, districts, hospitals and training institutions. However, the evolution of these meetings does not seem to have received well-managed attention to make them effective in as much as contributing towards their intended outcome: improved health system performance. Large inputs of effort and resources have brought them to the level they are now. Nonetheless, more effort is required beyond what this evaluation has brought out. This report therefore suggests these follow-up activities:

[7] A detailed sample has also been submitted outside this report due to size.

1) ZISSP should spearhead the development of guidelines for the quarterly review meeting that takes into account the recommendations in this report. The main focus of this guide should be around preparing for the meeting, managing the meeting and linking the meeting outputs to existing framework for planning (review of action plans) and supervision (Performance Assessment and Technical Support Supervision) as suggested in *Annexes 2 and 3*.

2) Beyond drafting these guidelines, ZISSP should rehearse with the government on training the relevant institutions in the implementation of the guidelines.

Given the remaining number of months beyond winding up the project, ZISSP may also consider finding ways of handing over recommendations from this report to the Ministry for other institutions to implement.

ANNEXES

Annex 1: Summary of Data Collection Methods and Associated Evaluation Questions

Data Collection Method	Evaluation Questions Intended to Answer		
	Input/Process	**Outputs**	**Outcomes**
Review of Records	- Was an agenda developed prior to the meeting? - Did the agenda clearly state the purpose of the meeting, key objectives and desired outcomes? - Were requests for inputs or presentations at the meeting clearly linked to the purpose and objectives of the meeting? - At the start of the meeting, did you (or the facilitator) review the agenda, the time lines for each topic and the reason for that topic on the agenda? - Did the meeting start within 5 minutes of the scheduled time? - Did the meeting follow the agenda and the allocated time lines?	- Did the report clearly document the expected meeting processes? - Did the report clearly outline the linkages between meeting presentations, discussions/ recommendations? - Did the report clearly list issues that needed attention after the meeting and clearly showed the timelines and responsible persons? - Did the meeting report include discussion of action points from the previous meeting with a clear indication of the roadmap for resolving issues that were still pending	- Did the report contain any information from any of the administrative levels indicating how resolutions from the previous meeting assisted in improving an aspect of health services/systems performance?
Key Informant Interview (One-on-One)	-	- Did each institution go home with a list of issues each needed to attend to after the meeting? - Was there a report arising from the meeting? - Was the meeting report circulated to participants and other stakeholders - Did the meeting report (if done) clearly show what was achieved from the meeting? - Did the meeting identify tentative agenda items for the next meeting?	- Are there examples of where an institution made a follow up on the action points which arose from the previous meeting(s) and was able to either report back to the next meeting or any other performance review meeting?
Perceptions Interview (Likert Scale)	Based on the past meeting(s), what is the opinion of the respondent regarding the following: - Was an agenda developed prior to the meeting? - Were participants able to provide input into the agenda? - Did the agenda clearly state the purpose of the meeting, key objectives and desired outcomes? - Did participants receive the meeting announcement and any background information in time to adequately prepare? - Were requests for inputs or presentations at the meeting clearly linked to the purpose and objectives of the meeting? - At the start of the meeting, did you (or the facilitator) review the agenda, the time lines for each topic and the reason for that topic on the agenda? - Did the meeting start within 5 minutes of the scheduled time? - Did the meeting follow the agenda and the allocated time lines?	Based on the past meeting(s), what is the opinion of the respondent regarding the following: - Documentation of key meeting decisions (Action Points)? - Developing tentative agenda for the follow-on meeting? - Drafting of the meeting report? - Circulation of the meeting report? - Detail and quality of the reports? - The future of the similar meetings?	Based on the past meeting(s), what is the opinion of the respondent regarding some institutions have used recommendations from the past meetings to improve quality of health services/system.

Annex 2 –Steps in Preparing for the Quarterly Review Meetings – Districts, hospitals and TIs

The proposed steps below are a summary of things that the district should do in order to improve efficiency of quarterly review meetings and enhance follow ups[8]. These steps are premised on the assumption that a revised minimum set of indicators on which review meetings would be based has been done and a common schedule for the meeting has been agreed upon for all provinces. This way, the districts would not have to wait until a meeting notification was sent before it initiated these steps. Maternal health indicators from the list that is currently in use during review meetings have been used as examples to demonstrate the steps below:

1. PREPARATORY STAGE

Step 1: Review of Data from the Current Quarter and Updating Past Quarters

Once data have been aggregated from all its facilities[9], the district should use the relevant procedures for generating summaries on the DHIS2.0 database programme. Once the raw figures have been processed, they should be transferred to the template, like the one below in Table 1a, to calculate the indicator to assess the performance level. The data source for columns (b) and (c) in Table 1a are indicated in parenthesis. Information for columns (e) and (f) should be provided by the HMIS team at the national level in collaboration with programme managers[10].

Table 1a: Sample Analysis Table for Maternal Health

Indicator Name	**Numerator**	**Denominator**	**Indicator value**	**District Target**	**Expected Minimum**	**Require intervention? (Yes/No)**
(a)	(b)	(c)	(d)	(e)	(f)	(g)
Average Antenatal visits	_____ Number of 1st Antenatal visits (*IRH1-025*)	_____ Number of all Antenatal visits (*IRH1-040*)	_____ Numerator / Denominator	4 visits	4 visits	_____
Percentage of deliveries by skilled personnel	_____ Number of deliveries by skilled personnel (*IRH4-035*)	_____ Expected number of deliveries *(computed)*	_____ Numerator x 100 / Denominator	rural 50% urban 80%	Rural 40 % Urban 70%	_____
Percentage of institutional deliveries	_____ Number of institutional deliveries (*IRH4-020*)	_____ Expected number of pregnancies *(computed)*	_____ Numerator x 100 / Denominator	rural __% urban__%	rural __% urban__%	_____

[8] What is presented here is a very short summary taken from Triple A protocol that was integral to the HMIS data use but have been de-emphasised over time.
[9] Use the existing standards for presenting information does not cover 100 per cent of all the units if some facilities have not reported at the time of preparing the report.
[10] Currently, MOH and MCDMCH do not have an up-to-date Indicators Manual, where all these measurements should be documented. This document must be produced if this proposal is to work.

Percentage of pregnant mothers receiving IPT3	_____ Number of pregnant mother given IPT3 (*IRH1-080*)	_____ Expected number of pregnancies (*computed*)	_____ Numerator x 100 / Denominator	rural __% urban __%	rural __% urban __%	_____

NOTE: This step should be repeated for all thematic areas such as Child Health, PMTCT, ART, TB, etc. Some thematic areas that do not have coverage indicators; in these cases the tables should be constructed differently. Table 1a is for demonstration purposes only.

Table 1b: Alternative Approach to Analysing non-coverage indicators – A sample

Question	**Numerator**	**Denominator**	**Indicator value**	**District Target**	**Expected Minimum**	**Require intervention? (Yes/No)**
Is the number of new malaria cases exceptionally high or low	_____ Number of new cases this quarter	_____ Number of new cases in same quarter last year	_____ Numerator x 100 / Denominator	<none>	85 - 115%	_____
Is the number of new antenatal clients decreasing?	a)_____ Number of new family planning clients	b)_____ Number of new family planning clients last quarter	_____ change: a-b	over 0 (or higher district target)	Below 0	_____
6. Is the number of new STD cases exceptionally high or low?	_____ Number of new cases this quarter	_____ Number of new cases in same quarter last year	_____ Numerator x 100 / Denominator	<none>	85 – 115%	_____
7. Is the number of new pneumonia cases among under 5s exceptionally high or low?	_____ Number of new cases this quarter	_____ Number of new cases in same quarter last year	_____ Numerator x 100 / Denominator	<none>	85 – 115%	_____
8. Is the number of new diarrhoea cases among under 5s exceptionally high or low?	_____ Number of new cases this quarter	_____ Number of new cases in same quarter last year	_____ Numerator x 100 / Denominator	<none>	85 – 115%	_____

Step 2: Selecting all indicators that require further intervention

Under each theme, select all indicators with a "Y" or "Yes" in column (g). Transfer all such indicators to the first column of Table 2a below.

Table 2a: Improvement Matrix for Maternal Health

Indicator needing attention	Identified Root Causes		Action points	Transitional target
	Description	Category		
Indicator 1	-			
Indicator …	-			
Indicator n	-			

Step 3: Problem Analysis and Plan for Action

Using any of the approved quality/performance improvement frameworks, identify root causes of the problem in a given indicator. For each identified root cause, under the heading "category", specify whether the identified root cause is "Easy to Tackle" (**E**), "Difficult to Tackle" (**D**) or Beyond Control" (**B**). Formulate an action point and the interim target for the indicator. This process should be done in a team by all district health office staff that has a role to in improving the performance of a given programme.

Step 3: Prioritise Activities for Action

Quarterly reviews, if done consistently, are likely to be done three times a year while the annual action plan is already running, with the fourth one combining the last quarter with the previous three to make it annual review. When the review is done in the middle of a running budget, it is imperative that the implementing unit selects activities that have a shorter execution time span and affordable budget. To do this, districts, hospitals and training institutions should review all Table 2's and pick action points by category and transfer the **E**'s, **D**'s and **B**'s to Table 3a, Table3b and Table 3c, respectively. Samples for Tables3a to 3c are shown below:

Table 3a: Interim Plan for "Easy to Tackle" Root Causes

Thematic Area	Action points	Implementation Period		Needed Resources	
		Start	End	Human/ Material	Financial
Thematic area					
Thematic area					

Table 3b: Interim Plan for "Difficult to Tackle" Root Causes

Thematic Area	Action points	Implementation Period		Needed Resources	
		Start	End	Human/ Material	Financial
Thematic area					
Thematic area					

Table 3c: Interim Plan for "Beyond Reach" Root Causes

Thematic Area	Action points	Implementation Period		Needed Resources	
		Start	End	Human/ Material	Financial

Thematic area					
Thematic area					

Step 4: Prepare Reports for the Quarterly Review Meeting

There are three inputs that districts, hospitals and training institutions should bring to the quarterly review meeting:

i) Status report on the action points that were not yet completed by the last meeting, action points formulated at the last meeting or after the last meeting for which implementation should have started before this meeting. This should be prepared as overhead presentations and each slide or a set of them should cover a particular thematic area, e.g., child health or maternal health. A sample format is presented in Table 4.

Note: Only those programmes for which action points were formulated should be presented.

Table 4 - Thematic Area 1: Status Report on Previous Action Points

Action points	**Planned End Date**	**Status**	**Successes and Challenges**

ii) Summary of performance in the quarter under review. This will be a summary of tables 1a to the last thematic area. These can be done as slides, using the example for maternal health as shown in Table 5a below:

Table 5a: Performance Report for Maternal Health Services

Indicator Name	**Indicator value**	**District Target**	**Expected Minimum**	**Require intervention? (Yes/No)**
(a)	(b)	(c)	(d)	(e)
Average Antenatal visits		4 visits	4 visits	_____
Percentage of deliveries by skilled personnel		rural 50% urban 80%	Rural 40 % Urban 70%	_____
Percentage of institutional deliveries		rural __% urban __%	rural __% urban __%	_____
Percentage of pregnant mothers receiving IPT3		rural __% urban __%	rural __% urban __%	_____

iii) Status report on newly-identified problems for which implementation of action points have not yet started. These refer to Table 3a, 3b and 3c. These tables should be presented to the meeting. For the mode of presentation, see the presentation stage.

2. PRESENTATION STAGE

As earlier stated, there are three "inputs" that each district, hospital and training institution is expected to bring to the quarterly review meeting, namely: status report on previous action points, performance during this quarter, and planned action points for problems identified during the period under review. The matrix below summarises the mode of delivering the content of each input during the meeting.

Step 5: Review of Progress from the Previous Quarterly Review Meeting

Input	**Method of Presentation**	**Expected Output**
#1. Previous Action Points	Mode: PowerPoint using the format shown in Table 4. Audience: Full meeting in plenary	Input from the meeting culminating into Revised Action Points.

Step 6: Presentation of the Performance Reports and Proposed Action Points

#2. Performance Report	Mode: Hand-outs in MS Word, as shown in Table 5a. Audience: This should be done through panel meetings whereby each group should be given thematic areas to review. Team composition should draw on specific specialities.	The expected output is a revised schedule of Action Points. These should combine uncompleted activities from the previous meeting (#1) and the revised list from #3 presented using the table format #3's. Note: This meeting output will be input #1 during the next meeting.
#3. Current Action Points	Mode: Hand-outs in MS Word as shown in Table 3a, 3b and 3c. Audience: This should be discussed concurrently with the performance reports in the same session and presented (theme by theme) to the plenary for final input.	

3. POST-MEETING STAGE

Step 7: Drafting a Tentative Plan of Action

By the end of the meeting each district, hospital and TI will have consolidated all their action points from the different groups that discussed the various thematic areas. The final meeting output for each of them will therefore be the revised tables that combine the output from the three inputs in section 2 above. It is recommended that the action points are grouped into two categories: those to be resolved by the district, hospital or training institution, and those requiring the intervention of the provincial or national office. Tables similar to the ones labelled Table 3 should be used as shown in Table 6 below.

Table 6: Implementation Plan for the coming period

Thematic Area	Action points	Implementation Period		Needed Resources		Level of Implementation
		Start	End	Human/ Material	Financial	
Thematic area						
Thematic area						

The last column "level of implementation" is meant to assist in distinguishing activities that will be done by the implementing units themselves from those that require the help of the province. Most the activities that will require the attention of the province are those that would have been categorised as "difficult to tackle" and "beyond control." During step 2, these would have been reviewed and the provincial authority would have taken a position on what can be done to help a particular institution.

Note: When the next review meeting is due, Table 6 will be used to prepare table 4 and part of the report by the province (as shown in *Annex 3)*. This step completes the cycle and feeds into step 1 for implementing units.

Step 8: Review of the Annual Action Plan

Once activities have been approved by the meeting, the next step is to ensure that those activities were included into the revised action plan. The next step therefore, after the meeting, is for each district, hospital and training institution to update its quarterly plan. All the protocols governing the review of action plans should be observed.

Annex 3 –Steps in Preparing for the Quarterly Review Meetings – Provincial Medical Office

The Provincial Medical Office is the convenor of quarterly review meetings. They provide a platform where the general performance of the province is assessed and an avenue for implementing units to share experiences and learn from each other. The proposed steps below are based on the same assumptions as the steps for districts, hospitals and training institutions as outlined in *Annex 2.*

1. PREPARATORY STAGE

Step 1: Review of data for the period under consideration[11]

Once each district has submitted the report for all the months to be included in the review, the province is expected to use the existing Data Quality Audit Protocols to verify the quality of data, focussing on completeness and consistency. Once the province has validated the data, the district or hospital should be notified to let them know whether the data was ready for use.

Step 2: Generate Assessment Tables for each District and Hospital

Since the core purpose of the meeting is to improve performance; performance improvement should implicitly encompass use of data for decision-making. It is important therefore that the province has an independent system for validating what the implementing units are bringing to the meetings are successes or challenges. Using the DHS2.0 the province should be produce tables similar to Table 1a in *Annex 2*. Differences in the indicators generated by the district and those done by the province are usually as a result of the discrepancies in the denominators[12]. These tables should not be circulated to the districts before the meeting as this may mask the actual problems on the ground; they should be circulated during the meeting when discussing input #2 and #3 in Step 6.

Step 3: Prepare a Report on the Previous Period

Two types of reports are expected to be presented by the provincial office. The first report should be an administrative update on any important events or announcements that have taken place since last meeting. The second report will be a progress report on the action points that were marked for the provincial medical office during the last meeting. This will be based on the last column of Table 6 for each implementing unit. The progress report should be presented using Table 4 shown in *Annex 2.*

2. PRESENTATION STAGE

There are three main products that the provincial medical office is expected to bring to the meeting: performance assessment tables, status report on the action points from the previous meeting, and administrative announcements.

Step 4: Make administrative announces

Contents of this report will vary from one meeting to the other. However, some of the issues that should be considered are: any announcements that have been made from the headquarters that may affect the way business is done; human resource status in the province; funds, transport and drugs in

[11] This step is very important as it minimises the risk of districts/hospitals coming to the meeting with information based on defective data; provinces have, in the past, disowned data presented by districts in meetings.

[12] Details are beyond the scope of this report

general terms. Such announcements can greatly improve on the efficiency of the meeting as they can pre-empt discussion during the meeting that may divert from course of the deliberations.

Step 5: Review of Progress from the Previous Quarterly Review Meeting

This step should precede step #5 for implementing units in *Annex 2*.

Input	**Method of Presentation**	**Expected Output**
#1. Previous Action Points (*that needed the PMO's attention)*	Mode: PowerPoint using the format shown in Table 4 in *Annex 2*. Audience: Full meeting in plenary	The presentation will inform the implementing units so that they update their Status Reports.

Step 6: Review of Performance Reports and Proposed Action Points for Districts, Hospital and TIs

The role of the province in this step is providing facilitation to the meeting. Specific programme officers should join respective groups that would be discussing thematic areas of their interest in Step 6 of *Annex 2.*

#2. Performance Reports (*produced by the province in step 2)*	Mode: Hand-outs in the format as shown in Table 1a from *Annex 2.* Audience: This should be done through panel meetings whereby each group should be given thematic areas to review. Team composition should draw on specific specialities	The expected output is a revised schedule of Action Points These should combine uncompleted activities from the previous meeting (#1) and the revised list from #3 presented using the table format #3's. Current Action Points for the province will be filtered from Table 6 in *Annex 2*. *For context, review steps 5 to 7 under *Annex 2* Note: This meeting output will be input #1 during the next meeting.
#3. Current Action Points (*same as in Step 6-Annex 2)*	Mode: Hand outs in MS Word as shown in Table 3a, 3b and 3c. Audience: This should be discussed concurrently with the performance reports in the same session and presented (theme by theme) to the plenary for final input	

4. POST-MEETING STAGE

Step 7: Preparing the meeting report

At the end of the meeting the provincial office should compile a report that focusses on the follow up. A detailed proposed outline has been submitted together with this report (but not in this report)

Note: Before the next review meeting is the report should be circulated to all districts and institutions.

Step 8: Follow up on Action Points

To ensure that action points from these meetings are implemented, the starting point is to certify that implementing units have included those activities into their revised quarterly plans. Once this has been done, existing structures for reviewing action plans can be employed besides the quarterly review meetings. Review of action plans is an integral component to the planning process and as such all emerging tasks (from quarterly reviews or any other source) should utilise this opportunity to ensure integration.

Annex 4 - Sample Meeting Evaluation Form

Please indicate the level of satisfaction you attach to each of the following statements by selecting a corresponding circle.

How satisfied are you:

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
With the quality of the overall meeting?	○	○	○	○	○
The subjects/topic discussed in the meeting?	○	○	○	○	○
With the usefulness of the issues discussed?	○	○	○	○	○
With the quality of the presentations in the plenary sessions?	○	○	○	○	○
With the quality of the group discussions?	○	○	○	○	○
That you had sufficient time to conclude all the sessions as planned?	○	○	○	○	○
With the amount of time allocated to the whole meeting?	○	○	○	○	○
With the meetings' overall value in helping you improve the delivery of health care	○	○	○	○	○
That the meeting has motivated you to go and do things differently?	○	○	○	○	○
That your contributions received the needed recognition?	○	○	○	○	○

What aspects of this meeting were particularly good?

What aspects of this meeting were particularly bad?

Do you have any suggestions or additional comments about this meeting?

Annex 5 - Sample for Taking Notes during the Meeting

[Meeting Title] |MINUTES

Meeting date | time *[Date | time]* | **Meeting location** *[Location]*

Meeting called by	[Name]	Attendees [Attendees]
Type of meeting	[Purpose]	
Facilitator	[Name]	
Note taker	[Name]	
Timekeeper	[Name]	

Agenda topics

Time allotted | *[Time]* | Agenda topic *[Topic]* | Presenter *[Name]*

Discussion [Conversation]

Conclusion [Closing]

Action items	**Person responsible**	**Deadline**
[Topic]	[Presenter]	[Date	time]
[Topic]	[Presenter]	[Date	time]

Time allotted | *[Time]* | Agenda topic *[Topic]* | Presenter *[Name]*

Discussion [Conversation]

Conclusion [Closing]

Observers [Name]

Resource persons [Names]

Special notes [Type additional notes here]

Annex 6 - Quarterly Review Meeting – Proposed Report Outline

1 Introduction

- 1.1 Provincial Profile
- 1.2 Reflection on the Previous Action Points
- 1.3 Summary of Opening Remarks
- 1.4 Aims and Objectives
- 1.5 Overall Objective
- 1.6 Specific Objectives

2 Progress Reports

- 2.1 Reporting Completeness
- 2.2 Financial Management
- 2.3 Child Health and Nutrition
- 2.4 Maternal Health
- 2.5 Obstetrics and Gynaecology
- 2.6 Surgical Service
- 2.7 HIV Counselling and Testing
- 2.8 Prevention of Mother-to- Child Transmission of HIV
- 2.9 HIV Treatment – Antiretroviral Therapy
- 2.10 Tuberculosis
- 2.11 Leprosy
- 2.12 Sexually Transmitted Infections
- 2.13 Malaria
- 2.14 Non Communicable Diseases
- 2.15 Neglected Tropical Diseases
- 2.16 Public Surveillance
- 2.17 Male Circumcision
- 2.18 Laboratory Tests
- 2.19 Pharmacy
- 2.20 Environmental Health
- 2.21 Human Resource and Administration
- 2.22 Human Resources – Teaching
- 2.23 Equipment and Buildings
- 2.24 Student Academic Performance
- 2.25 Academic Performance – Teaching Staff
- 2.26 Student Practical
- 2.27 Student Recruitments

3 Conclusion and Recommendations

Annex 7 – List of Persons Contacted

Date	Names	Position/Title	Location	Where Met	Type of Interview
16/10/13	Ms Musonda Kaluba	Management Specialist (ZISSP)	PMO, Ndola	Ndola	KII -one to one
15/10/13	Dr Peter Mulenga	District Medical Officer	DMO, Luanshya	Luanshya	KII -one to one
16/10/13	Wendy Njekile	Community Health Coordinator (ZISSP)	Copperbelt	Ndola	perception
14/10/13	Byce Kanyimbo	Senior Health Information Officer	Ndola Central Hospital	Ndola	KII -one to one
16/10/13	Chiima Chiima	Senior Clinical Care Officer	DMO Chingola	Chingola	KII -one to one
16/10/13	Dr Nyendwe	Head of Clinical Care	DMO Ndola	Ndola	KII -one to one
18/10/13	Mrs Zulu	Nursing Officer	Ronald Ross	Mufulira	KII one to one
18/10/13	James Malakata	Health Information officer	Ronald Ross	Mufulira	perception
15/10/13	Chumeli Munyinya	District Health information Officer	DMO, Ndola	Ndola	perception
16/10/13	Mrs Angola	MCH Coordinator	DMO, Masaiti	Masaiti	perception
16/10/13	Dr Chikowe	Head of Clinical Care			Perception
15/10/13	Ms Angela	Management Specialist	PMO Chipata	P.M.O Chipata	One on one
14/10/13	Mr Nkoma	Planner	P.M.O Chipata	P.M.O Chipata	One on one
14/10/13	Mr Choya	Acting Senior Health Information Officer	P.M.O Chipata	P.M.O Chipata	One on one
14/10/13	Dr. Pule	Clinical care specialist	P.M.O Chipata	P.M.O Chipata	One on one
17/10/13	Dr. Kandiwo	Hospital Administrator	Petauke District Hospital	Petauke DH	One on one
17/10/13	Dr. Mulambya	Disease control specialist	P.M.O Chipata	D.M.O Petauke	One on one
18/10/13	Royce Sakala	District nursing officer	D.M.O Petauke	D.M.O Petauke	One on one
14/10/2013	Dr. Musokotwane	Communicable Disease Control Specialist	PMO	PMO Choma	KII one to one
15/10/2013	Dr. Shawa	Hospital Administrator	Choma	Choma General Hospital	KII & Perception
16/10/2013	Mr. Kunda	Senior Information Officer	PMO	Provincial Office	KII & Perception
16/10/2013		Data Associate	DMO Choma	DMO Choma	KII & Perception
18/10/2013	James	Senior Clinical Care Specialist	Monze	DMO Monze	KII & Perception
18/10/2013	Mr. Sikaona	Clinical Care Officer	Monze	DMO Monze	KII & Perception
18/10/2013	Ngula	District Information Officer	Monze	DMO Monze	KII & Perception